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ASSOCIATED FEES—MEDICAL AND SURGICAL*

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THE chairman of the General Surgery Section of this society is honored in the privilege of addressing you in formally opening the session. Inclination impels toward some subject of scientific interest, but the technical side of the program will be ably cared for by the gentlemen to follow. For this reason your presiding officer has chosen to use the time allotted him in discussing a matter of interest to every surgeon and one even more interesting to his confréres on the medical side. It is not a pleasant subject, this matter of fees. We like to think of ourselves as scientists devoting our lives to the betterment of the physical condition of our fellowman. We believe ourselves to be all of this, but we should not fail to recognize the fact that economic factors will not be divorced from our profession until the remark of a famous Californian that "a man must eat" becomes untrue.

Let us then frankly consider the distasteful but nevertheless important financial side of our calling. And let it be understood at the outset that the purpose of this discussion is in the interest of honesty and fair dealing, to secure simple justice and full understanding between each of the concerned parties, namely, the patient, the referring physician, and the surgeon, while respecting strictly the dictum of our Code of Ethics as related to the division of fees.

The subject chosen, you will bear in mind, is "Associated Fees—Medical and Surgical." This limitation is made since it brings us directly to the discussion of a very real and as yet not satisfactorily solved problem in the practice of medicine and surgery. Until we find an answer the obnoxious subject of "fee-splitting" will be before us, and its general discussion can bring nothing but discredit to the profession. This subject was first introduced and the opprobrious name applied in an honest attempt to eradicate an unethical practice on the part of a comparatively few surgeons. Unfortunately the effect of the discussion has been to cast suspicion upon surgeons generally—upon a body of men whose unselfish devotion to duty and ethical standards are

* Chairman's address, Section on General Surgery, at the Fifty-Sixth Annual Session, California Medical Association, April 25-28, 1927.

such as to entitle them to commendation rather than to condemnation.

In an attempt to clarify the matter the following analysis of the conditions relating to fees is made.

Theoretically there should be no problem as to fees even in those cases where the internist and the surgeon have both a vital relation. Theoretically each has performed a service of value and each can present his bill and receive his pay directly from the patient. Practically this method does not function satisfactorily. This statement is made from an intimate knowledge of the experiences of many reputable men in our profession plus a personal observation over a number of years in general practice and of a greater number of years in work limited to surgery.

Why does not this simple, open and seemingly fair solution give satisfaction to all of those concerned, the patient, the referring physician, and the surgeon? The assumption is that all three are honest, for no rule can keep a crooked man straight, and this paper is addressed only to those who are seeking a fair solution of this problem. The answer to the above question is that it does not give satisfaction because the practical effect of the theoretical solution results generally in injustice to the referring physician. Any plan that is not just to all concerned is untenable.

Why does this theoretically ideal plan result in injustice to the referring physician? For two main reasons. The first is that, while the layman has been educated to understand and appreciate the value of a surgical service, he has not been taught to estimate the value of a medical service even though it may be equally vital as a factor in preserving health or life. The second is that surgery to the lay mind is dramatic and, therefore, an adequate surgical fee will be promptly and cheerfully paid, while in the same case a moderate fee for medical services will be questioned or repudiated.

To illustrate the practical results of this unfortunate and unjust condition, assume a typical example. A patient is ill and calls the family physician; several visits are made. Technical work and diagnostic acumen worthy of every consideration are brought into play. A correct diagnosis is made and an operation is found to be necessary. Then comes the exercise of much tact in convincing the patient and the family of the necessity for surgery. And do not underestimate the value of the possession of this ability, for without it the sufferer will be as unfortunately situated as though a wrong diagnosis had been made. The patient is taken to the hospital the surgeon concurs in the diagnosis and operates. Health is restored or a life is saved. Now, who will say that the surgeon has performed a service of greater value to the patient than has the physician, or that his technical skill is more worthy of reward than the competent generalship of his brother, the internist?

According to our ideal theoretical plan of managing fees each presents his bill. Without discussion you will probably visualize the surgeon's bill many times the amount of that which the physician would dare to present. Is this just? Your answer is: It is not. Yet these are the conditions under which we are working.

It was stated that to the lay mind surgery is dramatic. For this reason the probabilities are that the surgeon's bill for services will be promptly paid. This you say is a fortunate thing for him, but what has it to do with injustice to the physician. Again assume a typical example. The patient is ill and calls the family physician who successfully performs all of the valuable functions above described. The surgeon likewise does his part in restoring health. Under our ideal theoretical plan bills are again presented, but this patient differs from the former in that his finances are limited. He has enough to pay his hospital fees and his nurses, with two or three hundred dollars over for the physician and the surgeon.

The physician's work antedates that of the surgeon. We have admitted its relative importance. Unfortunately the patient does not see the values clearly. The obligation of the physician is accumulated gradually, so much so, that with it the patient acquires an immunity to a sense of his financial responsibility. The work of the surgeon is prompt, impressive, and, in the mind of the invalid, the vital factor in his cure. The services of the physician are given in the patient's home by a man who often has no thought of immediate compensation. The services of the surgeon are rendered in the hospital by a man who has learned the wisdom of having some definite understanding in advance about the fee. Is there any question as to who will receive his compensation? If there is need for deferred payments, is there a question as to who will do the waiting? Again, is this just to the physician?

The above examples are not exaggerated. They are typical of the experiences of everyone of us. If this be true we must conclude that the plan suggested to us for the collection of fees is ideal only theoretically. It cannot, without further education of the public, be made to function practically.

At this point lest there be a question of our loyalty to the Code of Ethics in its relation to the division of fee, let me hasten to add that the principles set down are not only theoretically ideal but that they are practically and justly workable, providing the surgeon is fair enough to cooperate with the physician, and providing the right methods are used in their application.

Fees are probably secretly divided much more commonly than we like to admit. Sometimes the practice is the result of unquestionable dishonesty, the purpose being to buy the support of the referring physician and by an addition to the statement for services rendered to have the patient pay the purchase price. This paper is not concerned with such individuals. They are few. They cannot be controlled by ethics. More often the practice is the result of an honest desire on the part of a conscientious surgeon to see that his medical confrére has fair remuneration. He argues that it costs the patient no more, since he makes no added surgical charge, and he knows, for the reasons given above, that the physician will not be justly treated if he attempts to collect in the way that he theoretically

could and should (and practically cannot) by the presentation of his own bill.

But be the motive honest or dishonest the practice of secret division of fees is not defensible. It lays the unselfish and honest surgeon liable to suspicion. It forms a precedent which the unscrupulous surgeon will use for his own dishonest practices and affords him just the opportunity which he desires to deceive and fleece the patient. It leads the layman further astray in his already wrong conception of the relative value of medical and surgical services. He feels that he has paid the medical man justly, since he has paid the bill as presented. He does not know that the surgeon has contributed to make the compensation just.

This brings us to a point where we can make a plain statement of the purpose of this address. It is proposed that in all cases where an internist and a surgeon have cooperated that their fees should be associated, that is, that one statement should be rendered, the bill being so itemized as to show definitely the obligation to each man. By this method the physician would make charges commensurate with his services, these to include a just estimate of the value of his diagnosis and advice. Since the bill would be a joint one, the surgeon would assume an equal responsibility for those items which might seem to the patient, in his misconception of relative fee values, to be overcharges, and, since he would be assuming this responsibility, it would be incumbent on him to explain why the physician's charges were just and why they they were quite as worthy of consideration as any work which he had done.

And this explanation is simple and to the patient educational. He should be made to understand that the so-called operative fee is in fact a fee which compensates for diagnosis, judgment, and for the operation. The surgeon in the case of an unreferred patient will fix a fee which in total compensates himself for all of these items of service. If one or two of these items of service have been performed by another, simple justice demands that the one who rendered the service should receive the reward. Nor should the patient be made this charge as an addition. It should be deducted from the statement of the surgeon, his bill having been rendered based on the assumption that he had performed all of the factors of the total service and being the same in amount as though the patient had come unreferred.

By this method the laity would soon become educated to a true conception of the relative values for medical and surgical attention. This plan would eliminate the present unjust situation which results in the surgeon alone receiving his fee where funds are insufficient for both. It would mean that both the physician and the surgeon would accept a proportionate discount on the value of their services where any reduction in bills was necessary. It would eliminate the excuse for secret money transactions and would acquaint the patient with every financial fact relative to his professional care. It would satisfy the honest physician, for it would secure for him as surely as for the surgeon the pay that he had justly earned. It should satisfy the honest surgeon—though it might pique the selfish one—for such a man would surely desire no unfair advantage over his brother on the medical side. The plan should function to the great satisfaction of both internist and surgeon in that it would enable them to uphold the spirit and the letter of our Code of Ethics with the full consciousness that each was being strictly just to the other while both were equally fair to the patient.

PROGRESS IN PEDIATRICS*

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IF there is one branch of scientific medicine that is advancing more rapidly than another, I think that distinction may be claimed for pediatrics. Probably that feeling is shared by a large number of physicians in our specialty. We have a general sense that this is true, but when one begins to compile actual facts and figures to prove the statement the results are astonishing. Progress in any line of scientific endeavor is necessarily slow. We press forward day after day and year after year doing our job as best we can. We gather bits of newer thought as we go along the way and weave them into the fabric of everyday practice. It may be likened to the man climbing up the mountain slope. The ascent is gradual and he feels sure that he is gaining heights, but not until he stops to look back does he realize just how far he has actually progressed.

Just for a few minutes we shall view the last few turns in the road over which we have passed and note the changes. Let us start at the beginning.

Studies in nutrition have proved beyond question that prenatal influences must be reckoned with if the best results in child culture are to be realized. Some of the obstetricians are taking cognizance of these facts, and they are to be congratulated. Closer relations between the obstetrician and the pediatrist are gradually being developed, and the next generation will benefit greatly because of this cooperation. The responsibility imposed upon the doctor who practices obstetrics—great as it ever was—is today even heavier because of recent discoveries in the field of nutrition. Formerly the accoucheur was concerned only with the more severe forms of toxemia of pregnancy and the safe conduct of labor, but today he must know that errors in diet during pregnancy may be responsible for deficiencies in the child that no amount of after care and feeding by the pediatrist can correct. Much can be done for deficiencies that occur after birth, but for those errors in the mother's diet that affect the teeth and other structures of the child in utero no correction can be made. Any physician who cares for pregnant women should study assiduously the newer books on nutrition and apply the knowledge gained to the careful regulation of habits and food of their patients. Do it for the sake of the child, as the full significance of diet in the developing embryo is just becoming appreciated.

THE NEW-BORN

In the many problems of the new-born the obstetrician is again involved, and his cooperation is asked. Many of the progressive men are asking the assist-

* Chairman's address, Pediatric Section, at the Fifty-Sixth Annual Session of the California Medical Association, April 25-28, 1927.